3260. INCOME AND RESOURCE ELIGIBILITY RULES FOR CERTAIN INSTITUTIONALIZED INDIVIDUALS AND CERTAIN INDIVIDUALS UNDER HOME AND COMMUNITY-BASED WAIVERS WHO HAVE COMMUNITY SPOUSES

Use the policies described in this section to determine Medicaid eligibility for persons--

- who are likely to be institutionalized in a medical institution and/or nursing facility for a continuous period;
- who have a spouse living in the community; and
- who live in one of the 50 States or the District of Columbia (i.e., these rules do not apply to the territories).

NOTE: YOU MAY APPLY THESE POLICIES TO PERSONS WHO ARE LIKELY TO RECEIVE SERVICES UNDER §1915(c) HOME AND COMMUNITY-BASED WAIVERS FOR A CONTINUOUS PERIOD. THUS, IF YOU ELECT THIS OPTION, PERSONS RECEIVING A COMBINATION OF INSTITUTIONAL AND WAIVER SERVICES ARE SUBJECT TO THESE RULES.

ALL REFERENCES TO INSTITUTIONALIZED SPOUSES AND CONTINUOUS PERIODS OF INSTITUTIONALIZATION INCLUDE SPOUSES RECEIVING HOME AND COMMUNITY-BASED WAIVER SERVICES IN LIEU OF INSTITUTIONAL SERVICES IN STATES ELECTING TO APPLY THESE POLICIES TO PERSONS RECEIVING WAIVER SERVICES.

These rules apply, even when they are inconsistent with other parts of the statute. In particular, these policies supersede:

- Section 1902(f) of the Social Security Act (the Act) which allows States to use eligibility requirements for the aged, blind and disabled which are more restrictive than those used to determine eligibility under the Supplemental Security Income (SSI) program;
- §1902(a)(10)(A)(i), which requires States to provide Medicaid to cash assistance recipients;
- §1902(a)(17), which contains comparability requirements.

These rules do not apply in the first full calendar month following changes in circumstances resulting in an institutionalized spouse no longer being institutionalized or no longer having a community spouse.

3260.1 Definitions.--Use the following definitions for purposes of this section.

Spouse.--Person legally married to another under State law. Depending on State law, this definition may be more restrictive than that used under the SSI program which uses a definition of couples that is very close to the definition of a "common-law marriage" which is no longer recognized in most States.

Institutionalized Spouse.--Institutionalized spouses are spouses who are likely to reside in a medical institution and/or nursing facility for a continuous period of institutionalization.

Community Spouse.--Spouses who are not living in a medical institution or nursing facility.

Medical Institutions and Nursing Facilities.--Hospitals, skilled nursing facilities and intermediate care facilities (including ICF-MRs) consistent with the definitions of such facilities under 42 CFR §§435.10094,40.40 and 440.150. Effective October 1, 1990, the terms "skilled nursing facility" and "intermediate care facility" are replaced by the term "nursing facility".

Continuous Period of Institutionalization.--At least 30 consecutive days of institutional care in medical institutions and/or nursing facilities.

Pending publication of regulations defining when a continuous period of institutionalization ends, you must adopt a reasonable policy. Absences from an institution for 30 consecutive days or a full calendar month are reasonable criteria. Thirty days is the same criteria used for defining when institutionalization begins for purposes of §1924 and absence from an institution for a calendar month is the criteria used under the SSI program to define when a period of institutionalization ends.

"Likely to Remain" in an Institution.--A determination by a State based on advice from persons States identify as persons in a position to assess individuals' circumstances.

Findings by such persons must support a conclusion that a person is "likely to remain" in an institution for 30 consecutive days. Evidence supporting a decision that a person is "likely to remain" in an institution for the specified time period may be obtained from such sources as a person's physician, hospital records, and case managers.

States must prescribe in their operating instructions who may render such decisions and what type of evidence is used to make such decisions.

Persons are considered "likely to remain", even though they do not actually remain in an institution, when it was determined at the beginning of the period of institutionalization that he/she was "likely to remain" for 30 consecutive days.

Countable Resources.--Resources not subject to exclusion under your Medicaid plan (i.e.,the cash assistance programs, or §1902(f) (in the case of States using eligibility requirements for aged, blind and disabled more restrictive requirements than the SSI program) or more liberal methods approved under § 1902(r)(2); except that, if not already excluded, funds set aside for burial must be excluded and the home, household goods, and one automobile in amounts not subject to dollar limits set forth in §1613(a)(2)(A) and (d) of the Act must be excluded.

Spousal Share.--One-half of couples' countable resources as of the beginning of the most recent continuous period of institutionalization.

State Spousal Resource Standard.--A minimum amount of couples' combined countable resources States decide are necessary for community spouses to maintain themselves in the community. Such standards may be no lower than $12,000 and no more than $60,000. The minimum and maximum amounts are increased for each calendar year after 1989 by the same percentage as the percentage increase in the Consumer Price Index for all urban consumers (all items; U.S. city average) between September 1988 and the September before the calendar year involved.

Spousal Resource Maximum.--Effective October 1, 1989, the maximum is $60,000. It is increased for each calendar year after 1989 by the same percentage as the percentage increase in the Consumer Price Index for all urban consumers (all items; U.S. city average) between September 1988 and the September before the calendar year involved.

Spousal Protected Resource Amounts.--Resources deducted from couples' combined countable resources for community spouses in eligibility determinations for institutionalized spouses. Amounts above spousal protected amounts are used to determine eligibility for institutionalized spouses.

Generally these amounts are the greater of the spousal share, or the State spousal resource standard not to exceed the maximum. However, in no instance is the protected amount lower than an amount ordered by a court of competent jurisdiction.

Spousal Resource Allowances.--The differences in the dollar value of resources protected for community spouses and the value of the resources actually held in the name of community spouses.

Promptly Assess Resources.--Within 45 days from the date of request for an assessment unless delays are due to non-receipt of relevant documentation or verification from the requesting party or a third party (e.g., a bank, an insurance company or brokerage) is received or within 45 days of receipt of documentation or verification when persons requesting assessments do not provide necessary information to States timely. States may not use the time standards as a waiting period, or as a reason for not completing assessments within the time frames.

A Support Right.--Pending publication of regulations, a reasonable definition is: The right of institutionalized spouses to receive support from community spouses under State law.

Assigned Support Rights.--Pending publication of regulations a reasonable definition is: An assignment of a support right allowing you to go against community spouses for reimbursement of some or all of the medical care provided to institutional spouses. You must assess your own State laws to determine what laws give rise to support rights and the amount of medical costs community spouses are asked to cover and whether you are limited to seeking support in the amount community spouses' resources exceed spousal allowances.

Undue Hardship.--Is defined by States and submitted to HFCA for approval as plan policy.

3261 INCOME ELIGIBILITY

3261.1 Income Eligibility Determinations for Institutionalized Members of Couples.--

When first determining eligibility :

o Use plan policies not governed by §1924 to define ownership in income.

o Do not deem income from a community spouse to an institutionalized spouse for any month of institutionalization.

o Compare institutionalized spouses' income after applying deductions specified in the plan to the appropriate eligibility standards for one person (i.e., categorically needy or medically needy).

Beginning with the first regularly scheduled redetermination of eligibility under 42 CFR §435.916 use the following rules governing couples' ownership in income to determine institutionalized persons' income eligibility, irrespective of State laws governing community property or division of marital property. These rules apply as follows:

A. Income from Non-Trust Property.--Unless institutionalized spouses establish by a preponderance of evidence through the fair hearings process that ownership interest is other than that prescribed below, use the following criteria to establish ownership in non-trust property.

o Consider income paid to one spouse to be the income of that spouse;

o Consider available to each member of a couple one-half of any income paid to both spouses;

o Consider income paid in the name of another party and both spouses, or one spouse, available to each spouse in proportion to each spouse's interest (or, one-half of the joint interest is considered available to each when payment is made to both spouses); and

o Consider available to each member of a couple one-half of any income which has no instrument establishing ownership.

B. Income from Trust Property.--Use usual plan methods and standards to evaluate trust property, except as provided:

o Consider available to each member of a couple, income from trust property in accordance with the specific terms of the trust; and

o When a trust instrument is not specific as to couples' ownership interest in income, determine ownership as follows:

- Consider income paid to one spouse to be the income of that spouse;

- Consider available to each member of a couple, one-half of income paid to both spouses; and

- Consider income paid in the name of another party and both spouses, or one spouse, available to each spouse in proportion to each spouse's interest (or, one-half of the interest paid to both spouses when the trust does not specify each spouse's individual interest).

Do not deem community spouses' income to be available to institutionalized spouses for purposes of determining such spouses' Medicaid eligibility for any month of institutionalization (including partial months). In this context, deemed income includes income of Medicaid eligible spouses as well as ineligible spouses.

Once ownership and the amount of income is established for institutionalized spouses, deduct from their income amounts specified in your plan. Compare the balance of remaining income to the appropriate income eligibility standard for one person.

3261.2 Income Eligibility Rules for Spouses and Other Family Members Living in the Community.--Use the rules which would normally be used to determine eligibility under your plan. Such rules may call for counting income and resources of institutionalized spouses for purposes of determining eligibility for community spouses and other family members, because community spouses and other family members are not subject to the special rules covered by this section. Such rules apply only to eligibility determinations for institutionalized members of couples.

3262 RESOURCE ASSESSMENTS AND ELIGIBILITY

Resource rules described in this section apply only to persons institutionalized for continuous periods on or after September 30, 1989. Persons institutionalized before that date are subject to your usual plan policies as long as they remain in an institution. When such individuals leave an institution and are readmitted for new continuous periods of institutionalization they are subject to the rules described herein.

These rules apply regardless of State laws relating to community property or to the division of marital property.

3262.1 Assessments of Couples' Resources.--Promptly assess couples' combined countable resources when requested by either member of a couple, or a representative acting on behalf of either spouse at the beginning of each continuous period of institutionalization. When such requests are made, advise requesting parties of the relevant documentation necessary to make assessments.

Documentation (or verification if deemed appropriate in lieu of documentation) showing ownership interest and current value of resources is expected to be provided. When necessary documentation and/or verification is not provided timely, advise requesting parties that assessments cannot be completed.

You may charge a reasonable fee for completing assessments which are not made in conjunction with Medicaid applications. Such fees must be reasonably related to the actual cost to you for completing assessments. Such fees cannot include the cost of computing spousal shares if you compute such shares at the time of these assessments.

Provide each member of couples with copies of the assessments (and the documentation used to make such assessments) and retain copies for your files. Also provide each

spouse with a notice advising them that only eligible spouses have a right to appeal your determination of countable resources at the time of the assessment, but ineligible spouses will have an opportunity to appeal assessment findings if and when their institutionalized spouses apply for Medicaid. (See §3263.)

Nursing homes in your State are required to advise new admissions and their families that resource assessments are available upon request. The right to be advised of such assessments is a patient right. Because of the link between this patient right and the eligibility process, you may establish additional procedures necessary to assure protection of this patient right. Thus, at a minimum, you must establish methods to monitor nursing homes to assure that they do advise individuals and their families of the opportunity for assessments. To assist nursing homes in carrying out this responsibility, you are encouraged to provide facilities with handouts explaining how and where to request such assessments and the type of information which must be provided to make assessments.

3262.2 Initial Resource Eligibility Determinations for Institutionalized Members of Couples.--Use the following rules to determine initial eligibility for the most recent period of continuous institutionalization.

A. Calculation of the Spousal Share.--The spousal share is equal to one-half of a couple's combined countable resources as of the beginning of the most recent continuous period of institutionalization. Spousal shares are calculated sometime between the time a spouse is admitted to an institution and the time that spouse applies for Medicaid and eligibility is determined. Thus, such calculations may be made even when there are no immediate plans for an institutionalized spouse to file for Medicaid.

The amount of the spousal share remains constant for purposes of determining the amount of resources used to determine institutionalized spouses' initial Medicaid eligibility in the current period. It does not change even when calculated prior to application.

No calculation of a spousal share is necessary or required when you elect as your State resource standard the maximum resource standard.

B. Initial Eligibility Determinations.--Except as specified in subsections C. and D., use the following criteria to determine Medicaid eligibility for the month of application for the current continuous period of institutionalization.

STEP 1. Determine couples' combined countable resources for the month of application or as specified in subsections C. and D.

STEP 2. Deduct from couples' combined countable resources owned at the time of application a protected amount which is the greater of the following amounts.

- o The spousal share, provided it does not exceed $60,000 (or the increased maximum established through CPI increases);
- o The State spousal resource standard;
- o An amount transferred under a court support order; or
- o An amount designated by a State hearings officer.

STEP 3. Compare remaining resources to the appropriate resource eligibility standard for one person. When remaining resources are equal to or below the standard institutionalized spouses are eligible. When remaining resources are above the standard, individuals are not eligible.

When resources exceed prescribed limits, individuals are ineligible until combined countable resources are reduced to the greater of the following:

- o States' spousal standards plus resource eligibility standards for institutionalized spouses;
- o Spousal shares plus resource eligibility standards for institutionalized spouses;
- o Court ordered spousal shares plus resource eligibility standards for institutionalized spouses; or
- o Spousal allowances determined necessary by a State hearings officer plus eligibility standards for institutionalized spouses.

EXAMPLE: A couple's combined countable resources at the beginning of the most recent period of continuous institutionalization are $120,000. Thus, the spousal share is $60,000 (i.e., one-half of $120,000). There is no court order. The couple's combined countable resources at the time of the institutionalized spouse's Medicaid application are $90,000. The State's spousal resource standard is $35,000. The eligibility resource standard in the State plan is $2,000.

Step 1. Deduct from current combined countable resources ($90,000) the greater of the following--

- o $60,000, the spousal share; or
- o $35,000, the State spousal resource standard.

$90,0000 - $60,000 =$30,000

The remaining $30,000 is an unprotected resource amount used to determine the institutionalized spouse's eligibility.

Step 2. Compare $30,000 to the resource eligibility standard of $2,000. The institutionalized spouse is not eligible. However, if during this same period of institutionalization, the couple's combined resources are reduced to $62,000, the institutionalized spouse becomes resource eligible.

C. Revisions to Protected Resource Amounts.--Spousal protected amounts are revised in three instances.

o When either member of a couple alleges that the initial determination was incorrect and State hearings officers confirm such allegations; or

o When you determine that inaccurate information was provided when you calculated a spousal share for the current eligibility period.

D. Exceptions to Resource Ineligibility.--Eligibility will not be denied institutionalized spouses who have resources in excess of the eligibility limits when one or more of the the following circumstances exist:

o All support rights of institutionalized spouses are assigned to States;

o Support rights cannot be assigned to States because institutionalized spouses have physical or mental impairments of a degree which under State laws prohibit them from legally assigning rights; and States have rights under State laws to bring support proceedings against community spouses without an assignment;

o You have determined that denial of eligibility creates undue hardship; and

3262.3 Redeterminations of Eligibility for Institutionalized Spouses.--Pending publication of regulations, deduct spousal allowance from resources held in the name of institutionalized spouses from the time of the determination of eligibility until the first regularly scheduled redetermination of eligibility. Community spouses' resources are not deemed to be available to institutionalized spouses. Institutionalized spouses's resources remaining after the deductions of spousal resource allowances are compared to the appropriate eligibility resource standard for one person.

When either member of couples establish that income generated from resources deducted as community spouses' spousal allowances are inadequate to raise community spouses' income to the minimum amount to be deducted as a maintenance allowance in the post-eligibility determination, substitute the resource amount calculated in subsection B, step 2. for amounts State hearings officers determine to be adequate to provide the minimum monthly income allowance. There are no substitutions when institutionalized spouses do not make available monthly income allowances to community spouses;

When there are changes in the amount of resources following the initial eligibility determination, recalculations of resource eligibility are made for institutionalized spouses, but spousal resource allowances are deducted in determining eligibility until the first regularly scheduled redetermination of eligibility under 42 CFR §435.916.

3262.4 Transfers of Resources Under §1924.--Once eligibility has been established, resources not used to determine eligibility for institutionalized spouses (i.e., the amount of spousal resource allowances) may be transferred to community spouses to assist such spouses in meeting their needs in the community. Thus, resources are not merely deemed available (or attributed) to community spouses in initial eligibility periods, but are actually made available to meet their needs in the community. Spouses who intend to transfer resources for this purpose are encouraged to do so as soon as is practicable before the first regularly scheduled redetermination of eligibility under 42 CFR §435.96. Resources transferred to community spouses as well as other specified parties, without receiving fair market value for the property transferred, do not adversely affect continuing eligibility of institutionalized spouses. (See §3252.)

EXAMPLE: A couple's combined countable resources are $20,000 at the beginning of the most recent continuous period of intitutionali-zation. Thus, the spousal share is $10,000. There is no court order. The couple's combined countable resources at the time of the institutionalized spouse's Medicaid application are $10,000. The State's spousal resource standard is $30,000. Of the $10,000 in resources owned by the couple, the resources owned by the institutionalized spouse are $8,000. The resource eligibility standard for one person is $3,000.

All of the couple's resources are protected for the community spouse because they are below the State's community spousal standard of $30,000. Therefore, the community spouse is resource eligible because his/her resources are below the eligibility resource standard. To remain eligible, the institutionalized spouse must reduce his/her resources from $8,000 to $3,000 by the time of the first regularly scheduled redetermination of eligibility.. If the institutionalized spouse chooses, he/she may transfer at least $5,000 in resources to his/her community spouse and help bring his/her resources up to the amount of the spousal allowance and retain eligibility.

Transfers of resources discussed in this section only pertain to transfers discussed in the law as they relate to §1924. The more comprehensive policies relating to transfers are covered in §3252. The more general provisions in §3252 overlap the provisions in §1924.

3262.5 Resource Eligibility Determinations in Retroactive Periods .--Apply the policies described in §3262.2 in the eligibility determination for institutionalized spouses for any one or more of the three months prior to application when the such spouses meet the requirement of §3260. Use regular plan policies for any month such persons do not meet the requirements of §3260.

3262.6 Multiple Applications in the Same Continuous Period of Institutionalization.--When a person is found to be ineligible upon application in the current continuous period of institutionalization and subsequent reapplications are filed in the same period, deduct spousal protected amounts from a couple's combined resources when determining eligibility for each application. Deduct spousal resource allowances until the next regularly scheduled redetermination under 42 CFR §435.916 following a determination of eligibility. Do not deduct spousal protected resource amounts when determining eligibility for persons reapplying for Medicaid following an initial certification of eligibility and subsequent determination of ineligibility in the same period of institutionalization.

3262.7 Eligibility for Community Spouses and Other Family Members.--Eligibility for community spouses and other family members does not change. Resources are considered under the eligibility rules which apply to the community spouse, irrespective of the rules governing their institutionalized spouses. This may result in counting institutionalized spouses' resources in eligibility determinations for community spouses for one month up to six months, because rules of the cash assistance programs require counting resources together for specified periods of time.

3263. NOTICE, HEARINGS AND APPEALS

3263.1 Required Notices.--After eligibility has been determined or an assessment of resoures is completed, provide written notice to both spouses including the following information as appropriate.

- o The amount of combined countable resources at the beginning of the most recent continuous period of eligibility;

- o The method used to compute the protected amount of resources used in the eligibility determination; and

- o Institutionalized spouses' right to rebut through a fair hearing ownership or availability of income and resources.

3263.2 Hearings and Appeals.--Provide a hearing under 42 CFR Part 431, Subpart E when an institutionalized spouse has applied for Medicaid and requests a hearing because he/she is dissatisfied with one or more of the following:

- o The computation of the spousal share of resources;

- o The computation of the spousal protected resource amounts; and

- o The computation of spousal resource allowances. Hearings requested on the basis of these computation must be conducted within 30 days from the date of request.

3270. DISABILITY DETERMINATIONS UNDER MEDICAID

These instructions implement 42 CFR 435.541, which covers the making of disability determinations by the States for the Medicaid program. The instructions implement requirements in 42 CFR 435.541 concerning the composition and qualifications of the individuals responsible for making disability determinations. These instructions also set forth the policy in 42 CFR 435.541 that, where separate applications based on disability have been filed with both the Social Security Administration (SSA) and the State, and different disability determinations are made by SSA and the State, the SSA determination is binding on the State to the extent discussed in §3270.2. Finally, these instructions implement the provisions in 42 CFR 435.541 that identify those circumstances in which a State should make its own disability determination.

3270.1 When States Make Disability Determinations.--

A. Make Disability Determination.--Determine whether an applicant meets the definition of disability for Medicaid purposes in any of the following situations:

- You use, pursuant to §1902(f) of the Act, a more restrictive definition of disability than that used by the Supplemental Security Income (SSI) program. (See §3271.)

- You do not have a §1634 agreement with SSA but otherwise use SSI criteria to determine eligibility and SSA has not determined that the applicant does not meet the SSI disability standard.

- The applicant has not previously applied for SSI as a disabled person and does not have an application pending with SSA.

- There is an application pending but SSA does not make a disability determination in sufficient time for you to comply with the time limit in 42 CFR 435.911.

- One of the exceptions in §3270.3 applies.

- Or, pursuant to §1902(v)(1) of the Act, you have amended your State plan to provide for making disability determinations prior to or while an SSA determination of disability is pending and until a final administrative determination is made on such application by SSA. (See §3272.2 for what we mean by final administrative determination.) If you elect the option under §1902(v)(1) of the Act, you must use the definition of disability in §1614(a) of the Act as reflected in 42 CFR 435.541 and §§3270-3276.

B. Do Not Make Disability Determination.--Do not determine whether an applicant meets the definition of disability for Medicaid purposes in any of the following situations.

- You have a §1634 agreement with SSA and the only application was filed with SSA.

o SSA has determined that the applicant does not meet the SSI disability standard and none of the exceptions in §3270.3 apply, and you have not elected this option under §1902(v)(1) of the Act to make an independent determination pending a final SSA administrative determination.

o You have an application pending but SSA makes a disability determination at any time before the expiration of the time limit in 42 CFR 435.911 for acting on your application, and you have not elected this option under §1902(v)(1) of the Act to make an independent determination pending a final SSA administrative determination.

3270.2 Precedence of SSA Disability Determinations.--As set forth at 42 CFR 435.541, an SSA determination that an individual is not disabled under the SSI disability standard has a binding prospective effect in all States, thereby precluding the affected individual from establishing Medicaid eligibility as a disabled individual, (1) until such time as SSA revises its disability determination, or (2) unless one of the provisions in §3270.3 applies, whichever occurs first. Where the affected individual is already receiving Medicaid, see §3272 for instructions about continued services and Federal financial participation (FFP). Where a §1902(f) State employs a more restrictive definition of disability, an SSA determination that a claimant for SSI or title II benefits is disabled is not binding on the State. However, an SSA determination that a claimant for SSI or title II benefits is not disabled, except as specified in §3270.3, is binding on a §1902(f) State because no State may have a more liberal definition of disability than the SSA definition.

3270.3 Exceptions to Precedence of SSA Disability Determinations.--In the following situations, States make a determination of disability even though the existing SSA disability determination is a denial:

o More than 12 months has elapsed since the last SSA determination denying disability and an applicant either (1) alleges that his/her impairment is more severe than at the time of the original determination, or (2) alleges an entirely new disability, and the applicant has not made application to SSA based on these allegations.

o An applicant alleges, at any time after SSA has denied disability, a disabling condition entirely different from the allegations upon which SSA based its decision, or an additional impairment(s) upon which SSA has not made a determination.

o An applicant alleges less than 12 months after the last SSA determination either that the disability which SSA evaluated has changed or deteriorated, or that he/she has a new disability upon which SSA has not made a determination and one or both of the following apply:

--The applicant has requested reconsideration or reopening of the last SSA determination denying disability and SSA has declined to consider the allegations concerning disability; and/or

--It is clear that the applicant no longer meets SSI eligibility requirements unrelated to disability status but may satisfy comparable Medicaid eligibility requirements.

3271. DISABILITY DETERMINATIONS IN §1902(f) STATES AND SSI CRITERIA STATES

If you do not have a §1634 agreement with SSA, you must in all cases make a Medicaid eligibility determination. (States with a §1634 agreement with SSA generally do not make a separate eligibility determination in the case of categorical applicants because Medicaid eligibility is determined by SSA.) When an applicant for Medicaid alleges disability as the categorical basis for eligibility, you are required to make a disability determination to the extent that there is no SSA disability decision, and the applicant is otherwise eligible for Medicaid. If SSA has made a determination concerning the applicant's allegation of disability and that determination is that the applicant is not disabled, you are bound by that determination to the extent provided in §3270.2. A separate determination of disability is not appropriate in such cases. If you use a more restrictive definition of disability and SSA has made a determination that the applicant is disabled, make a determination of disability using your more restrictive standard. This general rule applies to coverage of individuals in the mandatory categorical optional categorical, and optional medically needy groups.

3272. MEDICAID ELIGIBILITY QUALITY CONTROL (MEQC) TREATMENT OF PAYMENTS MADE DURING PERIOD YOU MADE A REASONABLE APPPLICATION OF SSI DISABILITY CRITERIA

Payments made on a State disability determination are not subject to being cited as erroneous in the MEQC process if you have made a reasonable application of SSI disability criteria in granting eligibility to an applicant for the period you were required to make a disability determination and thereafter until you are notified that SSA has determined the recipient not to be disabled. That is, the time during which a binding SSA disability determination does not exist or is not in effect as set forth in §§3270.1 and 3270.3. This period may be extended if the recipient requests an appeal of SSA's determination as described in §3272.2.

3272.1 When Payments Made Pursuant to State Disability Determinations Are Subject to Being Cited as Erroneous.--Payments based upon State disability determinations are subject to being cited as erroneous in the MEQC process if the following conditions exist:

- SSA has denied disability and that denial is still in effect during the review month, except as provided in §3270.2;

- You have received a State Data Exchange (SDX) tape from SSA as reflected on your system of records showing that disability has been denied with respect to an individual who either is a Medicaid applicant or recipient, and you fail to act upon the information received:

- You do not request notification from SSA (e.g., medically needy cases); or

- You have not taken timely action to redetermine Medicaid eligibility on a nondisability basis.

3272.2 Continued Benefits and MEQC Treatment of Medicaid Payments Made During an Appeal.--If an individual receiving Medicaid based upon disability is determined by SSA not to be disabled under the SSI disability standard, and he or she is not eligible for Medicaid on some other basis, such a recipient is nonetheless entitled to receive continued Medicaid coverage if he or she timely appeals the SSA disability determination pursuant to the SSA appeals process. Such an appeal is considered timely if filed within the time limit established in SSA regulations, and is sufficient to entitle the recipient to continued Medicaid even if the State does not have a §1634 agreement or applies more restrictive disability criteria under §1902(f) of the Act. (Medicaid is continued during the 60-day period within which an SSA appeal may be filed.)

Such an SSA appeal is considered to be a request for a hearing for purposes of (1) 42 CFR 431.230, which provides that, if a hearing is requested before termination of benefits becomes effective, Medicaid may not be terminated until a decision is made after the hearing, and (2) 42 CFR 431.250(a) and 435.1003(a)(3), which provide that FFP is available for Medicaid payments made after a recipient has requested a hearing, and until a decision is made following the hearing. A decision after the hearing occurs when the Medicaid recipient has no right to further administrative appeal, and the SSA decision accordingly is the final administrative decision. Thus, if the recipient fails to appeal an adverse Administrative Law Judge (ALJ) decision to the Appeals Council, and the Appeals Council does not otherwise decide to review the case, the ALJ decision becomes the decision after a hearing for purposes of continued Medicaid benefits once the 60-day deadline for requesting or initiating Appeals Council review has passed. If, however, Appeals Council review is timely requested or initiated, the decision after the hearing is the Appeals Council's final decision on the merits of the appeal or decision to deny review. Medicaid payments made in this situation prior to the final administrative decision described above are not subject to being counted as erroneous in the MEQC process.

3273. COMPOSITION OF DISABILITY REVIEW TEAMS

The disability review team must be composed of individuals described in 42 CFR 435.541(f)(2), and as described below.

3273.1 General Rules on Review Team Composition.--Disability determinations are made by a SA medical or psychological consultant and a SA disability examiner. (See §3273.2 for the definition of medical or psychological consultant.) The SA disability examiner must be qualified to interpret and evaluate medical reports and other evidence relating to the claimant's physical or mental impairments and as necessary to determine the capacities of the claimant to perform substantial gainful activity. (See 20 CFR 416.972 for discussion of substantial gainful activity.)

An initial determination by the SA that an individual is not disabled, in any case where there is evidence, which indicates the existence of a mental impairment, is made only after every reasonable effort has been made to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment. (See §3273.2 for the qualifications necessary for a psychologist to be a psychological consultant and §3273.3 for reasonable effort.) In a case where

there is evidence of mental and nonmental impairments and a qualified psychologist serves as a psychological consultant, the psychologist evaluates only the mental impairment, and a physician evaluates the nonmental impairment. The overall determination of impairment severity in combined mental and nonmental impairment cases is made by a medical consultant and not a psychological consultant unless the mental impairment alone justifies a finding of disability.

3273.2 Medical Consultant.--A medical consultant must be a physician.

3273.3 Psychological Consultant.--A psychological consultant used in cases where there is evidence of a mental impairment must, at a minimum, be a qualified psychologist. For disability determination purposes, a psychologist is not considered qualified unless he or she:

- Is licensed or certified as a psychologist at the independent practice level of psychology by the State in which he or she practices; and

- Possesses either a doctorate degree in psychology from a program in clinical psychology of an educational institution accredited by an organization recognized by the Council on Post-Secondary Accreditation; or

- Is listed in a national register of health service providers in psychology which the Secretary of Health and Human Services deems appropriate; and

- Possesses 2 years of supervised clinical experience as a psychologist in health service, at least 1 year of which is post masters degree.

3273.4 Reasonable Efforts to Obtain Review by a Qualified Psychiatrist or Psychologist.--

A. Obtain Services of Qualified Psychiatrists or Psychologists.--The SA must determine if additional qualified psychiatrists and psychologists are needed to make the necessary reviews. (See §3273.4B.) Where it does not have sufficient resources to make the necessary reviews, the SA must attempt to obtain the resources needed.

B. Action When Unable to Obtain Services.--Where every reasonable effort is made to obtain the services of a qualified psychiatrist or psychologist to review a mental impairment case, but the professional services are not obtained, a physician who is not a psychiatrist reviews the mental impairment cases. Every reasonable effort to ensure that a qualified psychiatrist or psychologist review mental impairment cases will be considered made only after efforts by the State as set forth in 20 CFR 416.1017 are complete.

3274. PROCEDURES FOR MAKING DISABILITY DETERMINATIONS

Make disability determinations based on medical and nonmedical evidence in accordance with the procedures specified in 20 CFR Part 416, Subpart I. Such evidence must include, but is not limited to, a medical report including a diagnosis. Use the procedures for evaluating evidence specified in 20 CFR Part 416, Subpart I to evaluate the evidence submitted to determine whether an applicant is disabled.

3274.1. Periodic Reexaminations.--In general, your review team must determine whether and when a reexamination will be necessary for the periodic redeterminations of eligibility required by §435.916. Use the principles and procedures in 20 CFR 416.989 and 416.990 when performing a reexamination of whether disability continues. However, if the recipient is receiving either title II or SSI disability benefits, do not reexamine the recipient's disability because any reexamination of disability is conducted by SSA. Reexamine disability only if such an individual stops receiving either title II or SSI benefits for reasons other than cessation of disability.

3275. COORDINATION BETWEEN STATE MEDICAID AGENCY AND THE SSA DISABILITY DETERMINATION SERVICE (DDS)

Maintain close links with the DDS handling SSA disability applications and with SSA. Where the component charged with making disability determinations for the Medicaid program and the component making SSA disability determinations are the same organization, make agreements to coordinate handling of applications for both programs. Where this arrangement does not exist, negotiate agreements with SSA and/or the DDS to share information.

3276. REFERRAL TO SSA

When you receive an application for Medicaid as a disabled individual from someone who has been denied disability under either title II or title XVI:

- Determine if any of the exceptions in §3270.3 to precedence of the SSA determination applies; and

- If the time limit for appeal of the decision has not expired, or the time limit for reopening has not expired, inform the applicant that a favorable decision is not possible at this time under Medicaid, and that if the applicant wants further review, he or she should seek an appeal/reopening of the SSA denial. Consider working with your parallel SSA district office to assist the applicant in either appealing or reopening the SSA decision. If SSA does not agree to hear such a request, you may make a determination pursuant to §3270.3.

3277. TIME LIMIT TO DETERMINE ELIGIBILITY IN DISABILITY CASES

42 CFR 435.911 has been amended to permit you a maximum of 90 days within which to determine eligibility when an applicant alleges disability as the categorical basis for eligibility. Because the amended regulations at §435.541 require greater coordination with the DDS where a duplicate disability application has been filed, establish procedures consistent with your administrative needs and practices to assure that a determination on the duplicate application is rendered within the maximum time limit.

3280 MANDATORY COORDINATION WITH WIC

Provide for coordination of Medicaid operations with the operations of your supplemental food program for women, infants and children (WIC). (See §5230 for coordination between EPSDT and WIC.)

3280.1 Mandatory Notice.--Provide written notice of the availability of WIC benefits in a timely manner to all individuals who are found eligible for medical assistance and who are:

- pregnant women;
- postpartum women during the six months after termination of pregnancy;
- women up to one year postpartum who are breastfeeding their infants; or
- children below the age of 5.

Provide this notice individually to each person listed above as he/she comes to your attention. No less frequently than annually, provide written notification concerning WIC, at a minimum, to all Medicaid recipients who are under age 5 or who are women who might be pregnant, breastfeeding or postpartum. Include in this notification information about the availability of WIC benefits and either the location or telephone number of the local WIC agency or instructions on how to obtain further information about WIC. Take all reasonable steps to provide this notification in an understandable manner to the blind, the illiterate, and those who cannot understand the English language.

3280.2 Mandatory Referral.--Refer all pregnant, postpartum or breastfeeding women and children below the age of 5 who are notified of the availability of WIC under §3280.1 to the local agency responsible for providing WIC services. Refer these individuals as they come to your attention.